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REPORT
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AUTHORIZING DEMONSTRATION PROJECTS IN CONNECTION WITH PROVIDING HEALTH SERVICES TO INDIANS

OCTOBER 3 (legislative day, OCTOBER 2), 1990.—Ordered to be printed

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Mr. INOUYE, from the Select Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 2850]

The Select Committee on Indian Affairs, to which was referred the bill (S. 2850) to authorize demonstration projects in connection with providing health services to Indians, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

PURPOSE

The purpose of S. 2850 is to authorize demonstration projects in conjunction with providing health services to Indians.

BACKGROUND

The Senate Select Committee on Indian Affairs has had a long-standing concern about the barriers many segments of the Native American population face in trying to gain access to health care. Many of these barriers mirror those faced by individuals living in the rural communities of our nation.

The following are among the specific barriers to health care facing individuals living in our nation's rural communities:

First, the lack of adequate public transportation and the existence of new local providers can make it difficult for many rural residents to reach facilities where they can receive care.

Second, economic barriers often make it impossible for many rural residents to receive adequate health care. And, often, economic barriers outweigh the strictly physical barriers.

S413-15

And, third, rural America is struggling to support its current complement of hospitals—in large part due to a lack of patients to support the operations of the hospitals as they are currently structured.

Just as Congress has been dedicating a great amount of effort over the last few years to helping to resolve these problems for rural areas, we believe Congress needs to be doing the same for Indian Country. And, just as is the case with rural areas, there is not one simple solution that would be appropriate for all tribes or Indian communities. Rather, those at the local level need to be empowered with the ability to explore options and initiate innovative solutions to these problems.

The Senate Select Committee on Indian Affairs has had a longstanding interest, stemming from the frequently expressed views of tribes, in whether there should be more flexibility in both the nature and scope of the health care delivery systems implemented in Indian Country, and in the resources used to pay for activities such as the construction of health facilities.

On March 22, 1990, the Committee held a hearing focusing on these issues. Specifically, the hearing focused on two questions related to Indian health care facilities and programs—primarily those in rural areas. First, whether there ought to be more flexibility in the type of health facilities that are constructed and programs that are implemented in Indian Country. And, second, whether the infusion of non-IHS dollars into the construction of health care facilities would improve the existing health care delivery system.

Perhaps no clearer evidence of Indian Country's interest in this issue exists than the fact that nearly three times as many tribes wanted to testify as the Committee could accommodate. It is the overwhelming response to the hearing, and the input received during and subsequent to the hearing as well as previously, that led to a decision to develop and introduce S. 2850.

This legislation empowers tribes and Indian communities to play a more direct role in developing and implementing health care delivery systems that they believe will best meet the health care needs of their specific communities. Tribal leaders and the Committee are excited about the scope and depth of the innovative ideas being developed in Indian Country to respond to this empowerment.

The concepts being developed range from outpatient clinics with overnight-stay beds—to treat conditions such as foot complications from diabetes or hydration—to wellness centers. Some tribes wish to have the opportunity to join forces with non-Indian communities and develop facilities that serve both Indians and non-Indians, or to be able to utilize non-IHS funds for the construction of IHS facilities. While none of this activity should be coerced, at the same time, this type of innovative cooperation should not be stifled. But, that is exactly what current policies are doing. S. 2850 was developed with the intent of reversing this trend.

Over the past several years, recommendations have come forward from the Indian Health Service to close or dramatically alter existing Indian health care facilities in favor of consolidating services or replacing an existing facility with one offering a scaled

down level of services. The Committee shares the concerns of many in Indian Country who feel that such actions may lead to a further deterioration in access to care, with the end result being a decline in health status rather than an improvement. On further exploration of this issue, the Committee found a wealth of ideas among those in the Native American community with regard to how resources might be used differently so that rather than decreasing access to care, access to care would be enhanced.

Specifically, S. 2850 would authorize at least nine demonstration projects to allow tribes to demonstrate some of their ideas about how their health care needs might be met more effectively and appropriately. In addition, projects would be provided in each of the following funding areas: 100% Federal IHS funding, a combination of Federal IHS funding and other resources, and 100% non-Federal IHS funding.

The foundation of this proposal if the concept of self-determination—providing tribes with the opportunities to have a direct hand in designing a health care delivery system which they believe will best serve the health care needs of their citizens. The Committee believes this approach to be the core of the policy of self-determination.

The Committee anticipates that all involved will learn a great deal through this process. Tribes will experience the challenges of planning, developing and implementing an effective program that serves the health care needs of their citizens. Tribes will learn from each other, as they observe the concepts that are explored by others throughout Indian Country. The Indian Health Service will learn in what ways it could be more responsive to the health care needs of Native Americans. And Congress and the Administration will learn what changes ought to be made to the existing service delivery system, including the construction priority system, as a result of the outcomes of the innovative concepts explored by the tribes.

Committee Amendment

At its September 12, 1990 business meeting the Select Committee adopted an amendment in the nature of a substitute by a unanimous vote. The substitute amendment reflects comments and imput made by affected tribes, Indian health and rural health experts, the Indian Health Service, and members of both the Senate and House. The test of the amendment is described in the "SECTION BY SECTION ANALYSIS" section of this report.

Legislative History

S. 2850 was introduced on July 12, 1990 by Senator McCain for himself and Senators Inouye, Burns, Conrad and Daschle, and was referred to the Select Committee on Indian Affairs. It was subsequently also cosponsored by Senators Gorton, Cochran, Murkowski, DeConcini and Burdick. The bill was considered by the Select Committee in an open business session on September 12, 1990, at which time an amendment in the nature of a substitute was offered by Senator McCain, and subsequently ordered reported.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

In open business session on September 12, 1990, the Select Committee on Indian Affairs, by unanimous vote of a quorum present, adopted an amendment in the nature of a substitute to S. 2850 with the recommendation that the Senate pass the bill.

SECTION-BY-SECTION SUMMARY ANALYSIS

SECTION 1—SHORT TITLE

"Innovative Indian Health Delivery System Demonstration Project Act."

SECTION 2—FINDINGS

The Act is not intended to alter the unique relationship between the Federal government and Indian tribes.

Every Indian tribe, regardless of its size, should have the ability to provide the highest level of health services to its people.

The Act shall not affect the existing Indian health facilities construction priority system and resource allocation methodologies.

The existing facilities construction priority system does not adequately serve all Indian tribes. There are some small Indian tribes or other tribes with a low patient workload at existing facilities which may require reconstituted IHS support.

There is a backlog in construction of Indian health facilities which will require at least $596,000,000 to remedy, and an essential repair backlog which will require at least $94,000,000 to remedy.

SECTION 3—PURPOSE

The purpose of the Act is to authorize demonstration projects which are intended to identify the most effective and efficient means of providing health care and essential health services for Indians.

This Act will:

(1) Enable Indian tribes to devise alternative health care delivery systems utilizing existing or new IHS resources combined with other resources;

(2) Enable Indian tribes to develop and implement financing mechanisms for health care services provided through an alternative delivery system; and

(3) Enable Indian tribes to fully utilize all available resources for the benefit of all community members, whether eligible or ineligible for services provided by the Indian Health Service, through an existing or alternative health care delivery system.

SECTION 4—DEFINITIONS

The Act provides for definitions of "Secretary," "Service," "Indian," "Indian tribe," "tribal government," "tribal organization," "area," and "service unit."

SECTION 5—DEMONSTRATION PROJECTS

(a) Projects to be established

Within 60 months following enactment, between 9 and 35 demonstration projects shall be established, at the request of a tribal government or tribal organization, to determine the most effective and efficient means of providing health facilities and services to Indian tribes. A demonstration project shall be located in each of the following service units: Cass Lake, Minnesota; Clinton, Oklahoma; Harlem, Montana; Mescalero, New Mexico; Owyhee, Nevada; Parker, Arizona; Schurz, Nevada; Winnebago, Nebraska; and Fort Yuma, California.

(b) Contracts; grants

For the purpose of carrying out a demonstration project under this Act, the Secretary may enter into contracts with, or make grants to, any Indian tribe or tribal organization.

(c) Construction; renovation

Demonstration projects under this Act may include the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services which meet the health needs of Indians.

(d) Waiver authority

For the purposes of this Act the Secretary is authorized to:

Waive any leasing prohibitions;

Permit carryover of funds appropriated for the provision of health care services;

Permit combining of inter-agency Federal and non-Federal funding;

Permit funds and property to be donated from or by any other source for project purposes, including other Federal agencies; and

Provide for the reversion to the donor of any real or personal property which may be contributed to a project.

(e) Geographic distribution

The Act provides for broad geographic distribution of demonstration projects. Notwithstanding the nine specified service units in section 5(a), the Secretary shall award at least one demonstration project in each area.

(f) Demonstration project allocation

Participation in demonstration projects under this Act shall not be based on the amount of financial resources held by an Indian tribe or tribal organization. All projects must include provisions for the demonstration of new or innovative delivery of health or health-related services.

Demonstration projects shall be awarded to at least three applicants (including the nine specified in section 5(a)) in each of the following categories:

Projects which involve the construction or renovation of facilities with funds from sources other than the Service.

Projects which involve the construction or renovation of facilities with a combination of both Service and non-Service funding, consisting of a combination of at least 25 percent and not more than 75 percent funding from the Service.

Projects which involve the construction or renovation of facilities with 100 percent from the Service.

SECTION 6—APPLICATIONS

(a) Procedures

Only Indian tribes or tribal organizations filing applications in conformity with this Act shall be considered for a demonstration project. The application shall require such information and be in such form as the Secretary shall prescribe.

(b) Abaement

Each application shall be accompanied by an assessment of the status of the Indian health services and facilities currently available to the applicant. It shall:

Be in such form as the Secretary shall prescribe;

Define the community and area to be served;

Specify the need for such a project;

Include a complete analysis of existing facilities;

Include a description of health services currently available, and the impact that the project would have on such services;

Include an assessment of staffing needs for the provision of services in connection with the project;

Include a description of funding sources available for current services;

Include a description of funding sources proposed to be utilized for the project.

(c) Proposal

Each proposal shall be accompanied by an application. The proposal shall:

Be in such form as the Secretary shall prescribe;

Be submited to the Secretary and the Area office in which the project would be located;

Describe the nature of facility to be constructed or renovated, and the health program to be carried out through the project;

Include data and information on which the proposal is based;

Describe the services to be provided by the project;

Include an explanation of factors making the project unique;

Include an assessment of costs of the project including operation and maintenance;

Identify and verify funding sources for the project;

Include a schedule for completion of any construction or renovation involved in the project;

Include an assessment of staffing requirements for the project; and

Include statements from tribal governments, tribal organizations and any existing health service delivery systems in the area which would be affected by the project.

(d) Area office

Each Area office receiving a proposal shall consider such proposal and submit its comments and recommendations on the proposal to the Secretary.

SECTION 7—APPLICATION SELECTION AND APPROVAL

(a) Consultation

After consultation with interested Indian tribes and tribal organizations, the Secretary shall establish criteria for the consideration and approval of applications submitted under the Act not later than 180 days after enactment. The criteria shall be published in the Federal Register.

(b) Congressional review

The Secretary shall provide Congress, 45 days prior to publishing in the Federal Register, a copy of the review criteria.

(c) Review panel

The Secretary shall establish a panel or panels to review, evaluate and rank applications. They shall advise and make recommendations to the Secretary.

Panels shall include at least one member who is a tribal representative, an IHS employee, an expert in rural health, and an Indian expert in health facility construction and program implementation.

(d) Considerations on review

In reviewing applications, the Secretary and Review panels shall consider, among other things, the following:

Whether the project will provide innovative health services to Indian people;

Benefits to the Indian community of the project;

Extent to which health services for Indians will be enhanced by the project;

Whether the project will provide new or expanded services;

Combined Indian/non-Indian patient workload in the project service area;

Economic viability of the proposed health care delivery or financing system and tribal administrative capability to provide the proposed services;

Determination of the cost benefit ratio of the project, taking into account the patient population workload and improvement in the quality of care;

Improved Indian patient access to health care resources and the value of such access in relation to total Federal funding and the overall health benefits to Indian tribes;

Identification of barriers to use of state resources;

How the project integrates facility master plans, and other national and area strategies for eliminating health deficiencies in accordance with the Indian Health Care Improvement Act;

Whether health care services for the Indian community will be impaired or diminished by the project; and

The ability of the Department of Health and Human Services to support he functions related to the project.

SECTION 8—TECHNICAL ASSISTANCE; BRANCH OF HEALTH FACILITIES DEMONSTRATION

(a) Assistance

The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with provisions of the Act.

(b) Branch of Health Facilities Demonstration

The Secretary shall establish, within IHS, a Branch of Health Facilities Demonstration within the Office of Health Programs, to oversee the projects established under the Act, and to coordinate the provision of technical assistance.

SECTION 9—HEALTH CARE SERVICES FOR INELIGIBLE PERSONS, AND FEDERAL TORT CLAIMS

Those under age 19, who are the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian, and not otherwise eligible for health services provided by the Service shall be eligible for all health services provided by a project on the same basis and subject to the same rules applying to eligible Indians under age 19. Existing and potential health needs of such individuals shall be taken into consideration by the Service in determining the need for, or allocation of, health resources or services.

The spouse of an eligible Indian who is not Indian, or who is of Indian descent but not otherwise eligible for health services provided by the Service, shall be eligible, as a class, if the governing body of the Indian tribe of the eligible Indian has adopted a resolution approving services for the class. Health needs of such persons made eligible for such services shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

An approved project is authorized to provide services to non-eligible persons who reside within a service area if:

The Indian tribe or tribes served by the project adopt a resolution approving delivery of health services to such individuals, and

The Secretary and the Indian tribe or tribes have jointly determined that:

the provision of such health services will not result in a denial or diminution of health services to eligible Indians, and

there are no reasonable alternative health facilities or services, within or without the service area of such approved project, available to meet the health needs of such individuals.

In cases where services are provided to non-eligible persons, the recipients of services shall be liable for payment under a schedule of charges approved by the Secretary. Amounts collected shall be credited to the account of the facility providing the service and

shall be used solely for the provision of health services within the facility.

For indigent non-eligible persons, services shall only be provided if an agreement has been entered into with a state or local government under which the state or local government agrees to reimburse the project for the expenses incurred for the provision of such health services to such indigents.

Health services may also be provided to non-eligible persons by a project in order to:

Achieve stability in a medical emergency,

Prevent the spread of a communicable disease or otherwise deal with a public health hazard,

Provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum, or

Provide care to immediate family members of an eligible person if such care is directly related to treatment of an eligible person,

Hospital privileges in health facilities operated and maintained by the project may be extended to non-Service health care practitioners who provide services to eligible persons. For the purpose of providing services to such eligible persons, health care practitioners shall be regarded as employees of the Federal government for the purposes of Federal tort claims only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

SECTION 10—REPORT OF FINDINGS; DISPOSITION OF PROJECTS AT CONCLUSION OF DEMONSTRATION

(a) Report of Findings

The Secretary shall, in consultation with Indian tribes involved in approved demonstration projects, prepare and submit to Congress, within 90 days following the 60 month period following enactment, a report on the findings and conclusions derived from the projects. The report shall include any suggestions the Secretary has regarding legislation and changes in existing Federal law as a result of the findings and conclusions.

(b) Disposition of Projects at Conclusion of Demonstration

Within 60 months following approval of a demonstration project, the Secretary shall make recommendations to Congress regarding designation of each project. Congress shall have one year to respond before the Secretary takes action on recommendations.

SECTION 11—REGULATIONS

Unless otherwise specified in the Act, the Secretary is not authorized to issue regulations with regard to provisions of the Act.

SECTION 12—AUTHORIZATIONS

For the purpose of making grants, or entering into contracts, to carry out the provisions of this Act, there are authorized to be appropriated such sums as may be necessary.

SECTION 13—AMENDMENT TO EXISTING LAW

The provisions of the act are to be added to the end of Chapter 18, Subchapter III of Title 25 U.S.C.

COST AND BUDGETARY CONSIDERATION

The cost estimate for S. 2850, as amended, as provided by the Congressional Budget Office is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 28, 1990.

Hon. DANIEL K. INOUYE,
Chairman, Select Committee on Indian Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has examined S. 2850, the Innovative Indian Health Delivery System Demonstration Project Act, as ordered reported by the Senate Select Committee on Indian Affairs on September 12, 1990. The costs of this bill are very uncertain, but, using one recent project as the model for costs of future ones, CBO estimates that this bill could cost the federal government between $2 million and $6 million in fiscal year 1991, increasing to between $3 million and $12 million in fiscal year 1995.

The bill would authorize the Secretary of Health and Human Services (HHS) to establish between 9 and 35 demonstration projects to determine innovative and effective means of providing health facilities and services to Indian tribes outside of the Indian Health Service (IHS) priority system. The type of demonstration projects that would be funded depends on future proposals and applications by Indian tribes. The possible costs of such projects range widely, from allowing Indian facilities to provide health services to non-Indian residents on a fee-for-service basis, which could have no net costs if fees were set high enough, to allowing tribes to construct new hospitals, which could cost several million dollars each. IHS would be responsible for fully funding a third of the projects that involve construction or renovation, funding up to 75 percent of the costs of another third, but would not be responsible for funding the remainder. Non-IHS funds could come from other federal agencies, states or local governments, or tribes.

CBO has assumed in estimating the cost of this bill that the new demonstration projects will be similar to the current Siletz project. This is because the Siletz demonstration project goals are nearly the same as those specified for the projects in the bill. For example, the Siletz clinic demonstration examines new ways of providing health facilities and services outside of the IHS priority funding process. The clinic provides ambulatory health services to Indians and to non-Indian residents on a fee-for-service basis. In total, the project cost $851,000 in 1990. IHS appropriations for clinic equipment, basic utilities, and 6 positions totaled $470,000 in fiscal year 1990. Funds for construction, totaling $381,000, were obtained from non-IHS sources. Ten percent of the non-IHS funds were obtained from the tribal council, while 90 percent of the non-IHS funds

came from two federal government agencies, the Bureau of Indian Affairs, and the Department of Housing and Urban Development.

If we assume that the demonstrations authorized by this bill are similar in scope and cost to the Siletz clinic demonstration, and, as in the Siletz case, that federal government agencies would provide 90 percent of the non-IHS funding, then each demonstration would cost the federal government an average of $820,000 in the first year, and about $220,000 in each of the following years. The Secretary of HHS would have 5 years after the date of enactment to establish these demonstration projects. While it is uncertain when costs would be incurred, CBO has assumed that one-fifth of the projects would be initially funded in each fiscal year, 1991 to 1995. Costs could be higher or lower depending on the size of the demonstrations.

The bill would authorize the Secretary of HHS to establish a Branch of Health Facilities within IHS to oversee the demonstrations and to provide technical assistance to applicants and grantees. Based on information provided by staff at IHS, CBO estimates that this provision would cost approximately $250,000 per fiscal year.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Karen Graham (226-2820).

Sincerely,

ROBERT D. REISCHAUER,
Director.

EXECUTIVE COMMUNICATIONS

Dr. Everett Rhoades, Director of the Indian Health Service, testified at the March 22 hearing before the Senate Select Committee. The text of his formal testimony, as submitted for the hearing record, follows.

In addition to his formal testimony, Dr. Rhoades indicated that he shared the concern of the Select Committee over the inability of the Indian Health Service to be more supportive of some of the real innovative programs that are being generated in various Indian communities.

STATEMENT OF EVERETT R. RHOADES, M.D., DIRECTOR, INDIAN HEALTH SERVICE

Mr. Chairman and members of the committee: I am Dr. Everett Rhoades, Director of the Indian Health Service. I am accompanied by Mr. Bill Pearson, Associate Director of the Office of Environmental Health and Engineering, and Dr. John Porvaznik, Associate Director of the Office of Health Programs. I am pleased to be here to address those issues concerning the delivery and maintenance of comprehensive, high quality health care to Indian and non-Indian people in rural America.

Many difficulties confront this country in providing quality health care to the Nation's population. In particular, the unique circumstances affecting rural populations have reached a critical stage and require careful consideration of a variety of issues. These include the availability

of routine care, levels of services which can feasibly be provided, and access to highly complex tertiary care. Rural populations are small, isolated and scattered. They frequently have additional problems such as poor transportation and high unemployment.

The difficulties faced by rural communities nation-wide are similar to those faced by the Indian Health Service (IHS) in its delivery of health care to Indian people. Because of the range and severity of the geographic conditions in some of these communities, IHS has encountered difficulties: in the recruitment and retention of qualified personnel; in balancing the demands for access while assuring high quality care; implementation of the most appropriate delivery system for a rural service area and in efforts to keep costs in control without affecting the level of quality of care provided.

I would like to discuss how IHS is addressing these barriers to health care and where our experience might be of benefit to both the Indian communities and their surrounding non-Indian neighbors in the development of innovative programs to meet their particular health needs.

The IHS is the largest most comprehensive rural health care delivery system in the United States. It provides a broad range of services to more than 1,000,000 Indian people. At present, Indian Health Service provides these services through 11 Area Offices which in turn direct the operation of 134 service units, 50 hospitals, 161 health centers and approximately 300 smaller health stations.

Preventive and therapeutic services are provided at all IHS and tribally-operated health care facilities. More specialized care is provided in three medical centers at Phoenix, Arizona; Gallup, New Mexico; and Anchorge, Alaska. Services that cannot be provided directly are purchased from the private sector utilizing contract health service funds.

Under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, and its Amendments of 1988, many tribes are now contracting to administer their own health care activities. These range from directing such specific programs as the invaluable Community Health Representatives (CHRs) or Community Health Aids (CHAs), to the management of their own hospitals and service units.

The central role the tribes play is critical. The tribes now have a dominant role in structuring the health services delivery system desired by their communities. It is important to understand that in the design and implementaion of any new and innovative health care delivery system, whether involving Public Law 93-638 or not, that involvement and acceptance by the affected tribe is essential.

Both tribal and IHS health care services encompass much more than the usual American concept of physician services rendered in a clinical setting. For example, health

promotion and disease preventive activities are integrated with the usual clinical services. Also, construction of individual and community water and sanitation systems is a critical component of the Indian health system, as is an active public health program using educators, public health nurses and community health representatives (CHRs). Many other examples could be provided.

In order to meet the growing challenge of providing a broad range of quality health programs, especially during periods of severe budget restraint, the IHS continually reviews its overall capabilities and the resources available to the various Indian communities. The need for these efforts was reinforced by Public Law 94-437. The Indian Health Care Improvement Act, enacted in 1976 and most recently amended in 1988. This landmark legislation authorized new programs and additional resources to enhance IHS to fulfill its goal of "raising the health status of Indian people to the highest possible level", as well as to "encourage the maximum participation of Indians in the planning and management of those services." This mandate requires IHS to devise new and innovative means of providing health care to Indian people.

A key element in the IHS program is the construction of modern facilities in which to deliver ever more sophisticated care. IHS continually reviews its construction program to assure that the facilities are utilized to meet the most urgent health care needs for IHS funded programs in Indian communities. IHS does this through a formal facilities planning and approval process. This process prioritizes needs for construction, replacement, or renovation/expansion for both inpatient and outpatient facilities. In this process, the IHS reviews such factors as the workload, the condition of the existing health facility, and the accessibility of alternative sources of care. These alternative sources are evaluated on the quality of care, willingness to absorb Indian patients, and the cost-effectiveness of purchasing health care services from them. The facilities planning process is reevaluated regularly by our Headquarters staff, with input form Area staff and tribal groups, to determine where improvements can be made in the methodology.

The IHS planning process prioritizes the need for facilities through the application of established criteria and methodololgy for national comparison and ranking purposes. It is, therefore, not unusual that some tribes will fare better than others, based on their overall characteristics of health care need. As a result, some tribes do not have the opportunity to obtain new or upgraded facilities.

There are many reasons for this, but it most commonly results from the fact that the number of Indian residents is too small or their homes too sparsely located; or the clinical workload is too small to ensure quality medical care.

Additional problems confront tribes which take the initiative to construct or obtain facilities on their own. The

IHS cannot, within our current policy provide funding for the staffing and operation of a new or expanded tribal health facility which was obtained using non-IHS funds. Nor do we support the construction or expansion of IHS facilities not on the construction priority list. We are presently studying whether some Indian communities, including new federally recognized tribes, may require special consideration.

When considering changes in delivery systems and tribal health administration, we believe there are several major elements that must be included:

Continued Federal support and flexibility in strengthening tribal management.

Clear identification of funding needs and sources.

Positive community relations and enhancement efforts.

Accountability and strengthening of tribal financial capability.

A clear definition of the risks and benefits of alternatives.

Development of a means of continually evaluating and maintaining the quality of program service.

Any future innovative rural health initiative affecting Indian people should also focus on the following concepts:

Maximization of all health care resources available to serve Indian people. This might include the use of IHS-tribal facilities by non-Indian patients for fee for service; and greater use of non-Indian facilities, such as local, private, State, Veterans Administration and military, to agument services to Indian patients.

Development of a cost-sharing mechanism that would reduce the financial constraints affecting the provision of health care at a local rural community level. This might include joint-use agreements; designing multi-purpose programs that would permit a local Indian community utilizing non-Indian patient populations to provide services at a local level that could not be justified by the population of either individual populations.

Exploration of the possibilities for new uses of underutilized space. Such space could be used to provide services ranging from health education, preventative health care services, to short-term treatment of aftercare services for specialized purposes.

Enhancement of transportation system to improve access.

In planning for any health delivery system, programs must maintain high quality and avoid duplicating existing programs. IHS supports the continued study of alternative methods to further fulfill the IHS mission of improving the health of Indian people. Once again, IHS emphasizes that tribal participation is mandatory in any new concept. I would like to reiterate that IHS's commitment to the important goals contained in both the Indian Health Care Improvement Act and the Indian Self-Determination Act will remain constant, regardless of the means devised to

facilitate the provision of health care to Indian communities.

In summary, IHS is committed to seeking ways of improving services to Indian people and we would be extremely pleased to work with you, members of the committee, the tribes and health professional consultants to devise ways to address the pressing issue of rural health in America.

Mr. Chairman, this concludes my prepared remarks and I would be happy to respond to any questions you may have. Thank you.

Regulatory Impact Statement

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 2850 will have minimal regulatory or paperwork impact.

Changes in Existing Law

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee states that enactment of S. 2850 will result in the following changes in existing law.

Subchapter III of chapter 18 of title 25 U.S.C. is amended by adding at the end thereof the following:

SECTION 1636. SHORT TITLE.

This Act may be cited as the "Innovative Indian Health Delivery System Demonstration Project Act."

SEC. 1637. FINDINGS.

The Congress finds that—

(1) there is a unique relationship between the Federal Government and Indian tribes, and this Act is not intended to alter that relationship;

(2) every Indian tribe, regardless of its size, should have the ability to provide the highest possible level of health services to its people;

(3) the existing Indian Health Service facilities construction priority system and resource allocation methodologies shall not be affected by this Act;

(4) the existing facilities construction priority system does not adequately serve all Indian tribes, there are some small Indian tribes or tribes with a low patient workload at existing facilities which may require reconstituted IHS support; and

(5) there is a construction backlog for Indian health facilities which will require at least $596,000,000 to remedy, and an essential repair backlog which will require at least $94,000,000 to remedy.

SEC 1638. PURPOSE.

The purpose of this Act is to authorize demonstration projects which are intended to identify the most effective and efficient means of providing access to health care and essential health services for Indians.

This Act will:

(1) enable Indian tribes to devise alternative health care delivery systems utilizing existing or new IHS resources combined with other resources;

(2) enable Indian tribes to develop and implement financing mechanisms for health care services provided through an alternative delivery system; and

(3) enable Indian tribes to fully utilize all available resources for the benefit of all community members, whether eligible or ineligible for services provided by the Indian Health Service, through an existing or alernative health care delivery system.

SEC. 1639. DEFINITIONS.

For purposes of this Act—

(a) "Secretary," unless otherwise designated, means the Secretary of Health and Human Services acting through the Director of the Indian Health Service;

(b) "Service," means the Indian Health Service;

(c) "Indian," means a person who is a member of an Indian tribe;

(d) "Indian tribe," means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) (43 U.S.C.A. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians;

(e) "tribal government," means the federally recognized governing body of any Indian tribe;

(f) "tribal organization," means any legally established organization of Indians which is controlled by one or more tribal governments or by a board of directors elected or selected by one or more tribal governments (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities;

(g) "area," unless otherwise designated, means one of the Area Offices of the Service as defined in 25 U.S.C. 1603(i); and

(h) "service unit," has the same meaning as that contained in 25 U.S.C. 1603(j).

SEC. 1640. DEMONSTRATION PROJECTS.

(a) PROJECTS TO BE ESTABLISHED.—The Secretary shall, within the 60 month period following the date of enactment of this Act, establish not more than 35 and not less than 9 demonstration projects to determine the most effective and efficient means of providing health facilities and services to Indian tribes. The Secretary shall establish, upon the application and at the request of a tribal government or tribal organization, a demonstration project located in each of the following service units:

(1) Cass Lake, Minnesota

(2) Clinton, Oklahoma

(3) Harlem, Montana

(4) Mescalero, New Mexico

(5) Owyhee, Nevada

(6) Parker, Arizona
(7) Schurz, Nevada
(8) Winnebago, Nebraska
(9) Ft. Yuma, California

(b) CONTRACTS; GRANTS.—The Secretary is authorized to enter into contracts with, or make grants to, any Indian tribe or tribal organization for the purpose of carrying out a demonstration project under this Act.

(c) CONSTRUCTION; RENOVATION.—Demonstration projects under this Act may include the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services which meet the health needs of Indians.

(d) WAIVER AUTHORITY.—Notwithstanding any other provision of law, for the purposes of this Act, and grants pursuant hereto, the Secretary is authorized to—

(1) waive any leasing prohibitions;

(2) permit the carryover from fiscal year to succeeding fiscal year of any funds appropriated for the provision of health care services;

(3) permit combining of inter-agency federal and non-federal funding;

(4) permit funds and property to be donated from or by any other source for project purposes, including other federal agencies; and

(5) provide for the reversion to the donor of any real or personal property which may be contributed to a demonstration project.

(3) GEOGRAPHICAL DISTRIBUTION.—In establishing demonstration projects under this Act, the Secretary shall, to the maximum extent feasible, provide for a broad geographical distribution of such projects among the Indian population. Notwithstanding the provisions of paragraph (a), the Secretary shall award at least one demonstration project in each area.

(f) DEMONSTRATION PROJECT ALLOCATION.—No Indian tribe or tribal organization shall be denied eligibility to participate in a project authorized by this Act based on the financial resources of the Indian tribe or tribal organizations. The Secretary shall select and award demonstration projects to at least three applicants in each of the following categories—

(1) Projects which involve the construction or renovation of facilities with funds from sources other than the Service, including those projects in the service units specified in Section 5(a) of this Act.

(2) Projects which involve the construction or renovation of facilities with a combination of both Service and non-Service funding, consisting of a combination of at least 25 percent and no more than 75 percent funding from the Service, including those specified in Section 5(a) of this Act.

(3) Projects which involve the construction or renovation of facilities with 100 percent funding from the Service, including those specified in Section 5(a) of this Act.

All approved projects under Section 5(f) must include provisions for the demonstration of new or innovative delivery of health or health related services.

SEC. 1641. APPLICATIONS.

(a) PROCEDURES.—Only Indian tribes or tribal organizations filing applications in conformity with this Act shall be considered for a demonstration project under this Act. Such application shall require such information and be in such form as the Secretary shall prescribe.

(b) ASSESSMENT.—(1) Each application for a demonstration project shall be accompanied by an assessment of the status of the Indian health services and facilities currently available to the applicant.

(2) Each assessment required by paragraph (1) shall—

(A) be in such form as the Secretary shall prescribe;

(B) define the community and area to be served by the project;

(C) specify the need or needs for such a demonstration project;

(D) include a complete analysis of existing facilities, such as space, structural deficiencies, and engineering requirements;

(E) include a description of the health services currently available to the population to be served, and the impact of the demonstration project on existing health services;

(F) include an assessment of the staffing needs for the provision of services in connection with such project;

(G) include a description of the funding sources which are available for current services; and

(H) include a description of the funding sources which are proposed to be utilized for the demonstration project.

(c) PROPOSAL—Each application shall be accompanied by a proposal for the establishment of a demonstration project for the delivery of health care services to the Indian tribe.

(2) The proposal shall—

(A) be in such form as the Secretary shall prescribe;

(B) be submitted to the Secretary and the Area office for the area in which the project will be located;

(C) include a description of the nature of the facility to be constructed or renovated, and the health care program to be carried out in connection with the demonstration project covered by the proposal;

(D) include the data and information on which the proposal is based;

(E) describe the services to be provided by the demonstration project;

(F) include an explanation of the factors which make the demonstration project unique;

(G) include an assessment of the costs of the project, including operation and maintenance;

(H) identify and verify the funding sources for such project;

(I) include a schedule for completion of any construction or renovation involved in any demonstration project;

(J) include an assessment of the staffing requirements necessary to carry out such project; and

(K) include a statement or statements from the tribal governments, tribal organizations and any existing health service delivery systems in the area which would be affected by the demonstration project.

(d) AREA OFFICE.—Each Area office receiving a proposal pursuant to subsection (c) of this section shall consider such proposal and

submit its comments and recommendations on the proposal to the Secretary.

SEC. 1642. APPLICATION SELECTION AND APPROVAL.

(a) CONSULTATION.—The Secretary, after consultation with interested Indian tribes and tribal organizations, shall establish criteria for the consideration and approval of applications submitted under this Act not later than 180 days after enactment. A copy of such criteria shall be published in the Federal Register not later than 180 days after the date of enactment of this Act.

(b) CONGRESSIONAL REVIEW.—Prior to the publication of the criteria referred to in subsection (a) of this section in the Federal Register, the Secretary shall submit a copy thereof to the Senate Select Committee on Indian Affairs and the House Committee on Interior and Insular Affairs. Receipt of such criteria by the Committees shall precede publishing in the Federal Register by 45 days.

(c) REVIEW PANEL—

(1) The Secretary shall establish a panel or panels to review, evaluate and rank applications. It should be the function of such panel or panels to advise and make recommendations to the Secretary.

(2) Any panel established pursuant to this subsection shall include at least one member who is a tribal representative, an Indian Health Service employee, an expert in rural health, and an Indian expert in health facility construction and program implementation.

(d) CONSIDERATIONS ON REVIEW.—In reviewing applications the Secretary and the review panels shall consider, among other things, the following:

(1) whether the demonstration project will provide innovative health services to Indian people;

(2) the benefit or benefits to the Indian community to be derived from the operation of the demonstration project;

(3) the extent to which health services for Indians will be enhanced as a result of the demonstration project;

(4) whether the project will provide new or expanded services within the existing health care delivery system, including but not limited to, services such as home-based care or swing-bed services;

(5) the combined Indian/non-Indian patient workload in the project service area specifically with reference to average daily patient workloads and the impact of the project on improved quality of care;

(6) the economic viability of the proposed health care delivery or financing system and tribal administrative capability to provide the proposed services;

(7) a determination of the cost benefit ratio of the project, taking into account the patient population workload and improvement in the quality of care;

(8) improved Indian patient access to health care resources and the value of such access in relation to federal funding and the overall health benefits to the Indian tribe;

(9) identification of barriers to the use of state resources;

(10) how the project will integrate with area facility master plans, other national and area strategies for eliminating health deficiencies in accordance with the Indian Health Care Improvement Act and how the project brings about an improvement in the level of need funded under the Indian Health Care Improvement Act;

(11) whether health care services for the Indian community to be served will be impaired or diminished by the proposed project;

(12) whether applicant is candidate for federal funding through the existing construction priority process; and

(13) the ability of the Department of Health and Human Services to support functions related to the demonstration project.

SEC. 1643. TECHNICAL ASSISTANCE; BRANCH OF HEALTH FACILITIES DEMONSTRATION.

(a) ASSISTANCE.—The Secretary shall provide such technical and other assistance a may be necessary to enable applicants to comply with the provisions of this Act.

(b) BRANCH OF HEALTH FACILITIES DEMONSTRATION.—The Secretary shall establish, within the Indian Health Service, a Branch of Health Facilities Demonstration within the Office of Health Programs, to oversee the demonstration projects established under this Act, and to coordinate the provision of technical assistance to applicants and grantees.

SEC. 1644. HEALTH CARE SERVICES FOR INELIGIBLE PERSONS, AND FEDERAL TORT CLAIMS.

For the purposes of this Act—(a)(1) Any individual who—

(A) has not attained 19 years of age,

(B) is the natural or adopted child, step-child foster child, legal ward, or orphan of an eligible Indian, and

(C) is not otherwise eligible for the health services provided by the Service, shall be eligible for all health services provided by an approved demonstration project on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date that such disability has been removed.

(2) Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible, as a class, if the governing body of the Indian tribe of the eligible Indian has passed by resolution approval for services to the class. The health needs of persons made eligible under this paragraph shall not be taken into consider-

ation by the Service in determining the need for, or allocation of, its health resources.

(b)(1) A demonstration project approved pursuant to this Act is authorized to provide health services under this subsection through health facilities operated directly by the approved project to individuals who reside within the service area of the project and who are not eligible for such health services under any other subsection of this section or under any other provision of law if;

(i) the Indian tribe (or, in the case of multi-tribal service area, all the Indian tribes) served by such demonstration project by resolution approves the delivery of health care services to such individuals, and

(ii) the Secretary and the Indian tribe or tribes have jointly determined that—

(I) the provision of such health services will not result in a denial or diminution of health services to eligible Indians, and

(II) there are no reasonable alternative health facilities or services, within or without the service area of such approved demonstration project, available to meet the health needs of such individuals.

(2)(A) Persons receiving health services provided by the approved demonstration project by reason of this subsection shall be liable for payment for such health services under a schedule of charges approved by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880(c) of the Social Security Act, section 402(c) of this Act, or any other provision of law, amounts collected under titles XVIII and XIX of the Social Security Act, shall be credited to the account of the facility providing the service and shall be used solely for the provision of health services within that facility. Amounts collected under this subsection shall remain available until expended within such facility.

(B) Under paragraph (1), health services may only be provided by an approved demonstration project to an indigent person who would not otherwise be eligible for such health services if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the approved demonstration project for the expenses incurred by the approved demonstration project in providing such health services to such indigent person.

(C) An approved demonstration project may provide health services under this subsection to individuals who are not eligible for health services provided by the project under any other subsection of this section or under any other provision of law in order to—

(1) achieve stability in a medical emergency,

(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard,

(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum, or

(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

(D) Hospital privileges in health facilities operated and maintained by the approved demonstration project may be extended to non-service health care practitioners who provide services to persons described in subsection (a) and (b). Such health care practitioners may be regarded as employees of the Federal government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

SEC. 1645. REPORT OF FINDINGS; DISPOSITION OF PROJECTS AT CONCLUSION OF DEMONSTRATION.

(a) REPORT OF FINDINGS.—The Secretary shall, in consultation with Indian tribes involved in approved demonstration projects, prepare and submit to Congress, within 90 days following the 72 month period following the date of this Act's enactment, a report on the findings and conclusions derived from the demonstration projects. The report shall include any suggestions the Secretary has regarding legislation and changes in existing federal law as a result of the findings and conclusions.

(b) DISPOSITION OF PROJECTS AT CONCLUSION OF DEMONSTRATION.—The Secretary shall make recommendations to the Congress regarding the designation of permanent status, discontinuation or modification of each of the demonstration projects. The recommendations shall be submited to the Congress within 60 months following the approval of the demonstration project to which the recommendations are directed, and the Congress shall have one year to respond before the Secretary takes action on the recommendations.

SEC. 1646. REGULATIONS.

With respect to the provisions of this Act, unless otherwise specified in this Act, the Secretary is not authorized to issue regulations.

SEC. 1647. AUTHORIZATIONS.

(a) GRANTS.—For the purpose of making grants to carry out the provisions of this Act there are authorized to be appropriated such sums as may be necessary.

(b) For the purposes of entering into contracts and otherwise carrying out the provisions of this Act, there are authorized to be appropriated such sums as may be necessary.

SEC. 1648. AMENDMENT TO EXISTING LAW.

Title 25 U.S.C., is amended by adding the provisions of this Act to Chapter 18, Subchapter III at the end thereof.

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